BODIES IN TREATMENT
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Learning From Work With Individuals With a History of Trauma

Some Thoughts on Integrating Body-Oriented Techniques and Relational Psychoanalysis

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Our thinking about working with and through the body in psychoanalysis extends a conversation already under way between psychoanalysis and traumatology. A recent paper by Ogden, Pain, Minton, and Fisher (2005) maps out some of the problems addressed in this nascent conversation, with the goal of enabling psychoanalytically oriented psychotherapists to include a body-oriented approach in order to deepen and make more effective their clinical work. Traumatologists such as Pat Ogden et al. (2005) or Peter Levine et al. (1997) have developed clinical techniques to work with people who have endured significant trauma that aim to enable the release of blocked responses to trauma that are encoded somatically. Their work rests on the proposition that the blocked trauma response stored in the body is most readily reached through attending to the body experience of both patient and therapist. Attention to mutual influence, although operationalized differently, is evident in innovative thinking about clinical practice including recent relational work on concepts such as the co-construction of experience (Stolorow & Atwood, 1992), mutual regulation (Beebe & Lachman, 2002), implicit relational knowing (Lyons-Ruth, 1998; Stern, 1998), mutual
recognition of subjectivities in thirdness (Benjamin, 1988; Ogden, 1994), and, crucially, multiple self-states and a dissociation model of the mind (Bromberg, 1998; Davies & Frawley, 1994).

A psychoanalytic approach has traditionally emphasized the construction of a narrative, thus engaging the part of the brain, the neocortex, where language is stored and processed. It must be noted that the trajectory of this process begins with the word applied to the body sensation and leads to the body’s relief. Knowing that traumatically experienced material is not encoded in a symbolic, but in a procedural, way suggests that we might rethink this. To that end, the work we attempt to describe here reverses this trajectory. P. Ogden et al. (2005) refers to this reversed trajectory as “bottom-up,” distinct from the “top-down” direction of creating a narrative that will provide more coherency. Memory, affect, and image arise from a deep, somatic source, not a verbal or a narrative source. The body experience is allowed to remain a body experience until its qualities can be felt fully, perhaps for the first time.

The traumatologists’ work suggests that a primary focus on the sensate experience of the client, rather than one emphasizing the cognitive or affective features of experience, enables the completion of a blocked response to trauma because the blocking and subsequent “storage” of the response to trauma is neurophysiologically determined. It is how our bodies work. This is not to say that cognitions and affects are neglected in the work. An emphasis on the sensate experience provides an organizing principle that creates reliable clinical traction because of an altered stance toward difficult transference/countertransference enactments.

A bodily focused technique might be described as a mechanistic approach and, as such, may be unappealing or troublesome to analytically oriented clinicians because we are challenged to take seriously the limits imposed by the ways our nervous systems are structured and function. Yet the proposition that changes in psychological state do in fact occur through unsymbolized, somatic intervention is hardly remote from most people’s daily lives. Most of us have first-hand experience of reaching a different quality of consciousness through concrete, mechanistic processes. The endorphin rush that one gets through vigorous exercise is perhaps the most common one; many have noted improvements like a more buoyant mood, clearer thinking, and a reduction of anxiety. The ancient Eastern Yogic tradition is another example. The physical practice of yoga postures produces a change in psychological state regardless of any ideological or spiritual commitment.

What we wish to point out is that these arguably mechanistic processes produce psychological benefits, through which an individual experiences herself in a different way without a cognitive, verbally encoded component. The symbolized component may follow the beneficial effect, but that symbolizing aspect of the experience is unlikely to be the sole cause of the beneficial effect.

We think it ought to be possible for psychoanalytically oriented therapists to benefit from this phenomenon, too. The benefits we have in mind are not limited to the patient. One of our concerns is the therapist’s self-care. Clinical work with individuals who have suffered significant trauma exposes the therapist to vicarious traumatization, the “negative transformation of the therapist’s inner experience as a result of empathic engagement with and responsibility for traumatized clients” (Saakvitne, 2002), a process that is not always obvious or easy to acknowledge for a range of reasons. We have found it all too easy to dissociate from our own needs for self-care. It has come to the attention of a number of professionals (e.g., Saakvitne) that there is little explicit support or guidance for remedying this lack. Therefore, our engagement of this conversation between psychoanalysis and traumatology explicitly includes developing ways to attend to the needs of both the therapist and the client to insure that the work is not injurious to either.

The conversation we hope to engage and to further here involves four distinct strands of inquiry. We have in mind contemporary researchers on attachment theory including, among others, Beebe and Lachman (1994, 2002), Tronick (1989), Stern (1985), and Lyons-Ruth (2005); research on affect, ranging from Tomkins (1962) to Schore (2003a, 2003b) and Fonagy, Target, Gergely, and Jurist (2002); neurological researchers Porges (2001), van der Kolk, McFarlane, and Weisaeth (1996), and Siegel (1999); and clinicians who specialize in trauma, notably P. Ogden et al. (2005) and Levine et al. (1997). Psychoanalysts have participated in this conversation from the very beginning of psychoanalysis, of course, but the contemporary interest in neuroscience can be traced at least to the late 80s, when Arnold Modell (1993), impressed by Edelman’s Neuronal Darwinism (1987), speculated that empirical studies someday would be able to show beneficial structural change to the brain as a result of psychoanalytic treatment. The recent work of psychoanalytic researchers
such as Schore and Fonagy et al. supports this hope. We find this way of thinking about body-mind to be deeply psychoanalytic. It is consistent with Freud’s (1895) original ambitions, with Ferenczi’s (1933) insights on the effect of trauma on the psyche, with Loewald’s (1960/2000) description of a neutrality based on love and respect for the individual and for individual development, and with Winnicott’s (1960/1965) emphasis that there is no way to think about the developing child’s psyche without also thinking about his somatic condition and development.

One of the challenges of this integrative effort is that the conversation involves divergent theories of mind and the languages in which those theories are expressed. It is a potential clash of metaphors. For some psychoanalysts, the neuropsychological data that reveals more detail of how the brain is structured and how it functions may not yet convincingly demonstrate the emergence of a model of the mind. Meanwhile, other analytic writers are more persuaded and have argued that the data from the neurosciences demonstrates that psychoanalysis has been right all along.

As we approach the question of comparing and integrating the disparate clinical approaches of psychoanalysis and traumatology, we encounter a significant gap. Whether this is bridgeable remains to be seen. That it might be bridged is of value because each discipline offers beneficial insights to the other. One manifestation of this gap is the problem of language. How can we create a space large enough to encompass these different languages and their overlapping areas of interest? We suggest that there is value in using data from neurophysiological work to refine clinical interventions. This is in the interest of broadening the continuum of effective work to include, at the same time, the duality of the concrete and the symbolic. By concrete, we mean that which is neurophysiologically determined. In the domain of the symbolic, the definition has expanded. Once, it described precisely that which can be put into words. Now, we understand it to include the area of implicit relational knowing, which by definition does not “rely on translation of these procedures into reflective (symbolized) knowing” (Lyons-Ruth, 1998, p. 283).

Another gap that needs attention is the problem of the reach or scope of the clinician’s attention. Because the traumatologists can neglect the transference/countertransference dimension of the clinical encounter, important aspects of clinical process, particularly that which is encoded as procedural knowledge that is enacted, can pass by unacknowledged and hence remain unanalyzed. And because psychoanalysis, the “talking cure,” has focused so much on the word, on making meaning, we believe that a psychoanalytic approach can minimize certain crucial aspects of the clinical situation, most particularly what is carried in and expressed through bodily states, the patient’s and our own, that cannot yet be put into words.

We believe that the insights derived from attachment studies, affect research, and the breakthroughs in neuroscience can form a kind of conceptual braid: They are mutually interimplicated. For example, the Boston Process of Change Study Group, in its investigation of how noninterpretive mechanisms lead to change and the question of what changes, look to cognitive developmental studies, neuropsychological data, and attachment studies to “refashion a psychoanalytic metatheory that is consistent both with the new research base and with a more fluid, mutual, and constructivist view of relational change in adulthood” (Lyons-Ruth, 2005, p. 579). Lyons-Ruth contends that “enactive knowing develops and changes by processes that are intrinsic to this system of representation and that do not rely on translation of procedures into reflective (symbolized) knowledge” (p. 579).

Clearly, not everything that contributes to changes in attachment style can be made explicit to a patient, nor ought that to be a goal. However, we suggest that this work includes a more expanded awareness for the therapist of what has often been taken for granted: tone of voice, pacing, gaze, and the therapist’s use of her body. By making what has been implicit more explicit to ourselves as we think about what we do and how we do it, we can use these aspects of ourselves more judiciously.

Understanding the client’s procedural knowing is expanded by the conceptual braid of neuroscience, attachment, and affect theory. The recent attachment research on the infant/caregiver dyad has indicated that the dominance of the right hemisphere of the brain in the first 12 months of extrauterine life enables only an implicit or procedural registration of affective experience (e.g., Schore, 2003a, 2003b). Fonagy et al. (2002) have argued that it is the caregivers’ crucially important task to help the developing child to regulate his affective state when his immature nervous system cannot do this independently. The caregiver in a sense lends her mature nervous system to
assist the child to develop the capacity for self-regulation, through which the child becomes able to develop a coherent narrative of his affective experience.

The research on the brain has shown us what this means biologically, physically, and structurally: that it is the right hemisphere dominance in development during this crucial phase that determines that it is the implicit or procedural register of experience that is possible for the infant. Schore (2003a) has compiled empirical evidence of damage to brain structure that is the result of the toxic biological environment brought about by abuse and neglect, which seems to confirm what clinicians have known for a long time: that there is indeed a cause-and-effect relationship between early experience and personality development.

We assume that we are familiar with the unfortunate results when caregivers cannot help the child develop the capacity effectively to regulate his affective state. We have inferred that severe personality disturbances are the sequelae of early experience of dysregulation and misattunement on the part of caregivers. For example, when discussing the intergenerational transmission of trauma, Main and Hess (1990) point out how the caregiver's inability to develop a coherent narrative for herself will drastically impinge on her capacity to help the dependent child to do so.

The “disorganized attachment” is the result of incoherent procedural messages predominant prior to the development of the capacity for declarative communication and this results in a neuronal structure distinctively different from an infant’s who manifests a secure attachment. The inability to maintain a coherent narrative will also manifest in a disorganized or otherwise stressful attachment style. The neuroscience studies of the biological and physical effects of this affective/attachment environment show us that a measurable paucity of certain neuronal connections is associated with this attachment experience, along with a preponderance of stress-related hormones present in the brain and bloodstream.

Conversely, when the primary caregiving environment has been one where the caregiver can maintain a coherent, declarative narrative, she is more likely to be able to assist the developing child in the differentiation of her affective experience and the creation of a coherent and declarative narrative of her own. “[M]ental coherence can be revealed within autobiographical narratives that ‘make sense’ of past experiences and their impact on present functioning as well as allowing the mind to create a sense of hope for the future. An individual moves from being the passive victim of trauma to the active author of the ongoing story of his or her life” (Siegel, 2003, pp. 52–53), which establishes coherence. To regard as “resistance” what may be structural, biological features of the nervous system of some of our patients may produce an iatrogenic reinforcement of the very difficulties that have made treatment necessary.

This conceptual braid guides our effort to develop technical approaches that will make psychoanalytically oriented treatment more useful to people with trauma histories. Specifically, this is a group of clients who are prone to dysregulation, who tend to become hyperaroused and flooded with flashbacks, or hypoaroused and frozen. Often these clients rely on dissociation from intolerable self-states. A more traditional, word-oriented technique, based on a repression model of the mind, often has an effect that is more disorganizing than with patients who have a more flexible array of defenses available. We’ve found that both our interpretations of the transfer, sometimes in relation to enactment phenomena, or our pursuit of a detailed inquiry of the narrative of the traumatogenic event(s) does not yield improvement, but rather unwittingly exacerbates dissociation by triggering the overwhelming situation that required, and continues to require, the dissociative response from the patient in order to survive. Often a patient will become hyperaroused, which can lead to a kind of psychic flooding, or hypoarousal, resulting in a retreat into a depressed withdrawal, in order to counteract the over-stimulation brought on by the attention to the narrative.

The technical suggestions we are thinking about ought not to be conceived of in a linear way in relation to psychoanalysis. This is not a preparation for the “real” work. It may be more helpful to think of an arc of a pendulum swinging between what we’d recognize as a relational psychoanalytic approach and one informed by the data recently available from the neurosciences.

Perhaps the central organizing principle for the clinician is the shift of attention from meaning making to tracking the client’s bodily sensation. Keeping in mind an understanding of brain anatomy and process, we suggest attending to the ways that we can help the patient stay in the area of felt sense. This involves maintaining the involvement with the instinctual or the reptilian brain and the limbic system, which is that part of the brain that processes nonverbal, affective experience.
This subcortically stored material, including but not limited to uncompleted fight/flight responses to threat, is often located motorically. It is not that the highly activated fight/flight response is in itself the problem; it is that it is uncompleted. Neuroscience data permits us now to understand that because the impulse is uncompleted, the limbic system continues to function as if the threat were still present. The nervous system has not been signaled that the danger is past, thus, the patient lives in a state of constant vulnerability to becoming highly activated by stressful situations and themes because the nervous system continues to respond as if there is danger everywhere. To enable the uncompleted impulse to move toward completion, we seek ways to slow down and focus the work, because the subcortical brain operates more slowly than the neocortex.

We conceptualize our thinking-through questions of technique with five major organizing principles, which we’ll illustrate in detail with clinical material:

1) Psycho-Education and Resourcing: We think of resourcing as beneficial for both the client and the therapist. We note that when we are more resourced, we are not so anxious and so are able to stay more present. By maintaining our differentiated state by not being caught in the overactivated state of the patient, we can provide the necessary support for the patient’s going on being, while protecting ourselves from being pulled into the collapsed repetition of the traumatic situation. Continued exposure to the horror of what many traumatized patients describe can make us vulnerable to the possibility of vicarious traumatization. Furthermore, our maintaining a state of differentiation preserves the psychic freedom to access a whole range of our emotions, including our own hopefulness and joy.

The more resourced the patient is, the better equipped she will be to negotiate the inevitable pull into the traumatic material. Providing information about how the nervous system is structured and functions often reduces a patient’s feelings of shame and badness. Finally, there is a comprehensible, reasonable explanation for many of the patient’s difficulties in functioning.

2) Directiveness: We will be describing a therapist who is far more directive and active than in traditional psychoanalysis. Our aim is to enable the client to access material from a different part of the brain, and this concept guides our interventions. Because free association can be too activating for patients with trauma history, the therapist cultivates the art of skillful interruption.

Although we do want to hear the whole story, we do not wish the patient to tell it in a way that will be dysregulating. The therapist may be attending to the potential arousing effect of the telling and may also wish to employ the technique of pendulation to support the patient’s self-regulation: The therapist gently directs a patient toward a more resourced, safe, capable sense of herself when we see, through careful tracking of the patient state, that she is approaching being caught up in the trauma in such a way that she will be required to use defensive strategies, such as dissociation, which do not permit any discharge of the now-blocked fight/flight response.

3) Use of Language: We are directive in a way that works, that is inviting, and, perhaps most importantly, that gives the locus of control to the patient. Inspired by Milton Erickson’s techniques, we may even ask the patient’s permission to ask a question. Our use of language is aimed toward facilitating the patient’s coherency.

4) Resources: Much of our directiveness will be in the service of helping the patient to develop a greater sense of having psychic resources. These can be conceptualized in roughly three categories: a) internal resources, such as the integrative capacities a patient may have, what ego functions are reliable, and how quickly they can reestablish themselves after becoming activated by traumatic material; b) interpersonal resources, that is, the relationship between the therapist and the patient, how reliable a working alliance might be, for instance, or the possibility for trust; and c) external resources, that is, actual things or activities in the patient’s life that the patient reliably and safely enjoys, or resources in imagination, like a superhero who comes to the rescue at stressful moments. The therapist may be called upon to be quite active, supporting and strengthening all categories of these resources.

A careful assessment of what resources are available to the patient is crucial. In those cases where there is little sense of having resources, the therapist’s creativity is called upon in helping the patient to build up a felt sense of safety that we then can refer to when pendulating between the traumatic material and a more resourced sense of self. If, for example, it is not possible to feel safe anywhere, or not possible to trust anyone, the point is not to validate that there is no possibility of safety or trust. By checking in a detailed way with the client’s felt sense over time, she might come to experience a gently expanding sense of relative safety.

The process of attuned pendulation toward and away from activating traumatic material will often lead to the completion of
the blocked fight/flight response. Involuntary muscle movements, signals that the blocked response is beginning to be expressed, are indications that this process is under way. This often scares the patient. She may want to control her movements. It is the therapist's job to support the patient through this loss of bodily control. At these times, explaining that this is the nervous system's way of completing the blocked impulse, and that this is how the nervous system regulates itself, can be extremely useful to the patient.

5) Transference and Transference Enactment: Beginning to work with the transference is done in a "nonpersonalized" way, or, as Winnicott (1960/1965) put it, as if we are the "environmental" mother, who can evolve as the patient's integrative capacity grows. We must be very careful to remember that the transference, or attachment style, is the only option for connecting. It is simply what relating is at present. Often, those who have survived a traumatic history are far more attuned to the affective states of others than their own. This awareness changes our theoretical and technical point of view. Rather than attempting to bring the quality of the transference to the attention of the patient, we see it as more effective to help the patient, in greater detail and for longer periods of time, to attend to her somatic experience as she relates to another, in the interest of promoting more self-regulation. We suggest that this is consistent with how Winnicott's "environmental mother" provides for the infant. Thinking transference in terms of ourselves as the "object" of transference wishes requires the patient to think of us in that way, which is an impingement. It is a crowding of the patient and inhibits her access to her own felt sense in the present. Thinking transference in this "nonpersonalized" way leads directly to reconsidering enactment.

Schore (2003a) defines enactment in a very specific way that is worth consideration. This definition is based on research on brain development, indicating that the right hemisphere develops very quickly and practically exclusively during the first 8 to 12 months of extrauterine life, during which period the neuronal pathways for processing affective experience and attachment are created. Thus, the primary caregiving relationship actually determines significant aspects of the brain's structure.

Enactment is ubiquitous, then, because it is determined by brain structure, the neurological connections established during the crucial period of the primary caregiving relationship. We suggest that enactments are governed by the attachment styles of both members of the analytic dyad. We agree that we are always participating in enactments, but we think of participating in a different way: We do not try to interpret, or to rely on a verbal communication to attempt to bring to the patient's awareness those experiences that are not encoded verbally. Prior to words being useful to a patient, our aim is to help the patient become more aware of her bodily experience, her felt sense in the here and now, as well as the way it shifts and modulates in response to internal and external stimuli.

We, as analysts, step out of a personalized view as a separate center of subjectivity, moving out of the "we" into curiosity about the patient's felt sense or bodily experience in the present. We understand the enactment as a way to reestablish the attachment that feels like what it is to be connected to an important other. Using the insights derived from the neurophysiological data, we suggest this is a way more effectively to put into operation the analyst's task of holding the particular self-states of both therapist and patient that are in the foreground at any given moment.

Clinical Illustrations

So far, we have detailed the theoretical reasoning that led to the formation of five organizing principles for thinking about clinical technique. Now we describe four events in the course of a treatment conducted by Christopher Eldredge to show how these technical suggestions might actually look in the clinical situation. It must be kept in mind that the pacing of these sessions is crucial. Long silences are frequent, as the therapist has learned to trust that the nervous system needs to take its own time to settle and regulate.

The first clinical moment we'd like to discuss focuses on the self-resources of both the client and the therapist, and the engagement with the patient's prefrontal cortex mode of experiencing in order to resolve a collapse into the complementarity of the perpetrator/victim relational configuration. This resolution also demonstrates the therapist's reliance on the "environmental transference." This is an example of a familiar, uncanny experience: the repetition of the enactment of the traumatic situation. In this clinical moment, from an early stage of the treatment with "S," the therapist feels pulled into the role of perpetrator with the client. He is aware of a bodily sense of tightness as he hears the client tell him she "knows" he is angry with her and
that he is likely to verbally attack her at any moment. It is apparent to
the therapist that she is experiencing some form of hyperarousal as
well as a freeze response, most notably evident by her dilated pupils,
shortened breathing, clenched jaw. Before he feels that he can help
her find surer footing, the therapist feels it is necessary to attend to
his own experience of dysregulation. He first physically moves his
body to a more expanded position that allows him to breathe more
easily and return to the clinical situation with more balance. Then, as
he works with the client's dysregulation, he eventually is able to help
the client regain access to her social engagement skills, as well as her
ability to more accurately assess a social encounter. Guiding a shift
from a mode of experiencing dominated by the trauma, where the
limbic system is the part of the brain most engaged, to a mode that
includes access to her prefrontal cortex, where greater differentiation
of affect is possible, is the therapeutic goal.

S: I know you're really mad at me. I'm five minutes late and this is the third
time this has happened and you're really fed up with me.
T: I hear that you're worried that I'm really mad at you, but I'm also notic-
ing that you seem really upset and a bit frozen. Do you feel that way?
S: Yes, I do. I have so many things to do today that I'm overwhelmed. And
I'm worried that I'm getting a cold and I may get sick just when I need to
be at my best for a team presentation at work.
T: How are you experiencing your body right now?
S: I'm tense, I'm tired and I also feel kind of numb.
T: Is there a place in your body where you don't feel numb or is it a more
general feeling?
S: I guess it's kind of general but it's more noticeable in my arms and legs.
T: Is there a place where you are aware of more feeling?
S: Well, not really. Maybe a bit in my feet.
T: You can feel your feet on the floor?
S: Somewhat.
T: Would it be all right with you if I asked you to stay with that experience
of feeling the contact of your feet with the floor for a moment?
S: Yes, that's O.K.
T: O.K. ...

(S. seems to relax a bit, her shoulders lower, her face looks less frozen,
and she sits back in the chair.)
S: I felt so spaced out when I got here.

(The therapist senses some room to check with S.'s actual experience
of him in the present.)

T: Would it be all right with you if I asked you to look at me directly?
S: O.K. ...

(Gradually she raises her head and looks into the therapist's eyes.)

T: Is your actual experience in the moment that I am angry at you for being
late?

(At first there is no response. As S. looks at the therapist, her eyes
become red, and after a moment she speaks.)

S: Well, actually you don't really seem mad to me.

Rather than interpret the transference enactment, the therapist
has maintained attention on the bodily experience of the pair, first
on his own, and after achieving a more regulated sense of himself, on
the client's. With the guidance of the therapist's questions about her
bodily experience, the client is able to regulate herself more effect-
ively, which leads her to be able to encounter the therapist in the
present, rather than in the context of the traumatic situation. Here,
the therapist's intention is to support the client's capacities for self-
regulation so that confronting the traumatic material can be useful,
rather than leading to a retraumatizing repetition.

The second clinical moment illustrates the value of including
psycho-education at appropriate moments. This vignette also dem-
strates the use of pendulation from a feeling of being securely
resourced to the edge of a trauma vortex, working with overcoupled
beliefs, and the use of invitational language to support the client's
sense of being in control. The work also involves attention to the
disorganized and hostile/dependent forms of attachment. Addition-
ally, this is an example of the use of countertransference disclosure
regarding the dilemma confronting the pair.

This clinical moment begins with the therapist's awareness of
the client's highly agitated state when she enters the room. He can
anticipate from previous experience with her that she is likely to
begin crying in a way that will make it very difficult for her to speak
once she has regained her composure. When this has happened on
previous occasions, she has said that she knows it was a mistake for
her to come to the session. In an attempt to slow down what feels like the inevitable collapse of the working alliance, the therapist clearly sets out this dilemma:

T: I sense that given how upset you appear to be that if I sit here and let you express what you are feeling with no comment, that you’ll begin to cry very hard, become hoarse, and then say that you shouldn’t have come. On the other hand, if I ask if we can slow down the experience that you are having, that you will tell me that you feel I am trying to silence you the way your father always did. It seems that what has gotten put together for you is the belief that you have only two choices when it comes to self-expression.

Either you say what’s on your mind, which often includes expression of strong emotion that will eventually feel injurious to you, that is, you’ll be hoarse or the person to whom you’ll be speaking will become punitive, or you have to be calm and “nice”—not causing any overt distress to yourself or others. But that tack will leave you feeling completely erased.

S: That’s true.
T: So how would you like to proceed given that dilemma?
S: (after a pause) It feels like a bit of a relief to know that neither of those choices is really very satisfying. No wonder I feel so helpless. I’m not sure what to do, but I’m glad you asked me.

The third clinical illustration demonstrates how to stabilize the client who has dropped into a highly dissociated state, while also showing how the use of resources can help to mobilize the client’s blocked fight response in relation to her aggressive and terrorizing father. The therapist keeps working in a nonpersonalized transference by keeping the focus on tracking the client’s experience of her body, encouraging her to slow down her physical movements so that her nervous system can experience the full benefit of her completed fight responses. As this occurs, and she has a more up-to-date experience of herself, the client is more able to experience her social engagement ability in relation to the therapist, who is no longer experienced as a “giant.” Also, as the therapist encourages her to pendulate between her present experience of strength and her terrified, younger self-state, the client not only experiences her current ability to defend herself, but she also gains the ability to have compassion for the little girl in this flashback who was all alone with no one to protect her.

The vignette begins at the moment the client enters the therapist’s office, flustered by being 20 minutes late.

S: I know you’re furious with me for being late.
(S. is very agitated, talking rapidly, and rocking in her chair.)

T: It can happen that people are late sometimes.
S: No, you’re really mad at me. I’m sorry.
T: I know that you’re upset, thinking that you kept me waiting. Could we slow things down a little bit?
S: I can’t hear what you are saying. I see your mouth moving but I can’t hear what you’re saying. It’s foggy.

(The therapist realizes that the client is in a highly dissociated state and attempts to work with this collapse.)

T: As you notice the fog, what are you aware of in your body?
S: I’m small and it’s still foggy.

(The therapist seeks to help S. connect to a resource that will address her collapsed, dissociated experience by attempting to shift her focus to something that she has previously reported as a resource that helps her to feel strong and present.)

T: In this moment you’re feeling so much distress, what is it like to remember your friend, Sonia, and how much time the two of you spent laughing at the silliest things?

(S. smiles at first, then lowers her head.)
S: I’m always making mistakes and then I get yelled at. Nothing will ever change. I can’t ever get it right.

(She moans and begins rocking.)
T: You don’t make mistakes with Sonia.
S: Yes, but Sonia’s different.

(S. begins to make fists as she says this.)
T: I know you aren’t always comfortable hearing me mention things that I notice about your physical expressions, but I can’t help noticing that you’re making fists as you say that Sonia is different.
(S. pounds the armrests on the chair.)

S: Sonia doesn’t judge me or yell at me.
T: Who does?
S: My father; he thinks he knows everything.

(S. is clearly returning from a collapsed, dissociated place with a lot of energy in her body.)

T: It looks as if your hands and arms want to move in some way. Is that true?

(She squeezes her fists more tightly.)

S: I’d like to punch him and get him out of my face!
T: How would it be to experience your fists and arms as sources of strength as you defend yourself from your father?

(There begins to punch vigorously into the air.)

T: Would you be willing to slow the action down a bit to give your nervous system the chance to deeply experience your competent fighting responses?
S: I’m scared. What if it doesn’t work?
T: Just try to stay with your physical experience for a moment. Right now, you’re here with me in the safety of this office.
S: I see his ugly, red face close to mine, yelling.
T: As you see that image, what do you notice in your body?
S: I feel my fists get tighter. I want him to shut up and get away from me.
T: Let your fists and your arms move if they want to.

(When she slowly begins to punch forward with her fists. As she speeds up, the therapist asks her to see if she can keep the movement slow and deliberate so her muscles and nervous system get the benefit of deeply experiencing the completion of her powerful and competent fighting movements to defend herself.)

T: How is that for you, to take charge of the situation in this way?
S: (smiling) It’s weird, but it feels kind of good ... different, I guess. I’m not used to feeling this way.
T: What way?
S: In control and solid ... and ...
she continues to follow the involuntary movement of her writing hand. In this place of thirdness, or the transitional space of curiosity and possibility, the client can use the therapist as a resource to help her connect the dissociated parts of her frightening experiences that have heretofore only made themselves known in unverbalized, procedural ways. Crucial to this sense of resolution will be the completion of the response of disgust, so often an important component of the relational trauma and betrayal where the victim's inherent, authentic sense of self has been poisoned.

This vignette illustrates what Benjamin (1999) describes as "affective, symbolic play which allows two partners to construct a dialogue [that] positions the third in terms of the music or dance that two partners follow .... [It] is as if we were sight-reading an unknown score, We make it up as we go, yet it feels as though we are oriented to something outside. If feels discovered as well as invented" (p. 206).

S: I'm so afraid, I'm freaking out. If I don't get that report done, I'll be fired. I can't do it.

(He grasps her sides and begins to moan as she rocks back and forth.)

T: Is there any place in your body where you feel a bit more relaxed?
S: No.
T: Do you have feeling in your body, right now?
S: No, I'm mostly numb.
T: Mostly numb. Is there any place where you have feeling in your body?
S: My back, I can feel my back on the chair.

(Attending to her back is the point of entry to a more resourced physical experience of herself.)

T: Good. Just take a moment to notice the feeling of your back against the chair.

(As she does, she takes a deep breath and exhales. S. remains still for a while, then spontaneously grasps an imaginary pen and speaks.)

S: I can't write. Something very bad will happen if I do. I don't know what it is, but it is very scary. I see hands around me and I know that I'm about to be murdered.

T: As you notice how afraid you are, is there any place in your body where you feel a bit less frightened?
S: No, I'm writing now, well, not really writing, I'm signing something. I'm signing a consent form that will allow me to walk into a burning building.

(S. is slowly moving her imaginary pen.)

T: I'm wondering if there is a way to slow this down. Perhaps there is a way to see about getting the fire out in the building before proceeding. What do you think?
S: No, this is inevitable, all that is required now is my signature.

At this point, it is clear to the therapist that his attempts to steer S. into a safer direction aren't working. He realizes that his mounting anxiety is reinforcing her experience of helplessness and feeling alone. He removes his attention from S. and focuses on his own body experience, to attend to his own anxiety, and eventually to feel more centered. He silently says, "I trust my ability to balance myself, and I trust my ability to make contact with S. when I am more centered." He notices that he feels more relaxed and he can breathe more easily. Shortly after this exchange with himself, something quite unexpected happens. S. puts down her imaginary pen.

S. starts to move her hand back and forth in the air. She isn't looking at the therapist. First, the movement is a gentle oscillation back and forth with her writing hand. Before long, she starts to move her other hand in a similar way.

T: I notice that you're moving your hands.
S: Yes, I'm feeling freer. I'm little and happy. I see myself reaching for a sink to wash my hands. It's fun. I'm splashing in the water. I'm excited because I'm going to a birthday party. What a great day, a party to go to. Then my mother slaps my hands and tells me I'm taking too much time to get ready. I'm shocked. I was just being happy. I didn't even spill any water on the floor. Why did she do that? I see her rough hands drying mine off.

T: Your mother couldn't be with your excitement then.

(S.'s face turns sad and anxious as she continues to make splashing motions, reaching up to the sink.)
S: Now I see other hands. I'm in bed with my father, who is laughing with me, but then he touches me in a way that makes me feel uncomfortable... touching me the wrong way. I feel happy to be with him but then scared and ashamed that he’s touching me like that. Now, I'm back at the birthday party. I don't care about being there. I just sit in a chair. One of the mothers thinks that I might be shy and tries to get me to join in with the other kids, but I don't. I don't care about it at all. My mother finished off any fun. I just wait to go home. It is as if my fun self has been killed off. Just like in the bed. I was laughing until my father touched me the wrong way, and then fun was killed off. I just turned to stone.

T: Something is fun, like splashing in the sink and laughing with your father in bed, and then the fun is killed off.

S: Yes, that's right, that's exactly how it happened. Then I'm a stone. I don't care about anything fun. It doesn't matter. Other nice people try to come to engage me, but now I'm gray, I just see those nice people through a fog. I see their faces, but I can’t really hear them. I don’t do anything spontaneous. I just do my homework. People leave me alone when I'm at my desk doing my homework.

T: Do you like being at your desk, doing your homework?

S: Not really, but no one bothers me because that's what I'm supposed to be doing.

T: Do you remember doing anything else as a young person that was spontaneous that you actually enjoyed for which there were no negative consequences?

(S. makes a spontaneous hand movement. Her hand springs up and down.)

S: Yes. I used to be a springboard diver. I had a coach who was nice and my parents were never there. He was nice to me. While it was exciting, it could also be very scary. Particularly, three-meter springboard diving. You're high up, and you're doing a complicated dive. The first couple of times you need another pair of eyes watching until your body remembers what to do and when to do it. If your coach doesn't spot you correctly by calling you out of that dive at just the right second, you can have a bad accident and really hurt yourself.

T: You have to trust the person in charge of your safety.

S: Yes, you have to keep track of where the water is as you spin or you're lost. I'm spinning. I can see the water in the sink. Then I see the hands on me in the bed. I lose myself in the dive. I can’t find my way and there isn’t a good person spotting me. I lose my orientation to the water and crash. I’m finished. No coach. Just corrupt people. I hit the water and go under. No one to pull me out.

T: No one is watching out for you. It's very sad.

S: (taking a deep breath) Yes, it's sad. I haven't thought about those things for a long time. And I never connected any of it to the birthday party, to the bed with my father and my diving coach. I'm thinking about it. I feel nauseous. It's really awful. No wonder I don't think about these things coherently, it is really atrocious. No wonder I would want to sign a death warrant for myself. There is no way to win.

T: What do you notice in your body as you say, “There is no way to win”?

S: I feel some relief because it is true. There wasn't any way to stay open in such a dangerous environment. I feel sad. I was smart enough to get through an awful life with scary people. No wonder I become anxious about writing. Look at what would come out of my pencil if I had known all this. I probably would have been even more thoroughly obliterated if I had been able to say any of these things. I guess I did enjoy a kind of damage control, my limiting their concerted effort to killing off my joy and trust.

T: What is it like to say all this? What do you notice in your body as you put these images and thoughts together?

S: I've been ashamed of hiding for so long, when it turns out to be the very thing that may have saved my life. I also feel that you were a good spotter while I was up there in the middle of that high, difficult dive. You didn't get in my way, but somehow I knew you were there if I needed a spot. You were watching, but you let me wander where I needed to go, flow with the water, from the sink, to the diving board, to the bed, then out of the pool to safe ground. It's a lot. Yes, it's sad, but I don't feel crazy or ashamed. I'm amazed. I don't know where all those images and thoughts came from. I just followed my hand. I feel great relief. I know what I've just said is related to my anxiety about writing, but in this moment, I don't even care about that. I feel relieved to know what is bothering me and to feel a lot of shame leave. I'm feeling relieved. I'm tired, but I feel good.

Conclusion

We've presented a way of working that seeks to keep in play that which is more concrete, realistically recognizing the limits imposed by the structure and functioning of the nervous system, with what traditionally has been regarded as the symbolic, but now includes the domain of enactive relational knowing. The more literal, concrete interventions inform both the therapist's sense of thirdness and the patient's, which expands each partner's capacities to experience
greater subjective complexity. In work that focuses on sensate experience, patients gain some freedom to allow for the completion of blocked responses to trauma. Working this way aims to include these historical events in a more flexible and resilient self-experience in the present, rather than triggering a dissociative response that obliterates dialogue between different experiences of self. We understand dialogic to be a process where each mode is preserved, and each can catalyze the other in an ongoing process. The enactive relational mode and its cognitive, symbolic counterpart are each accessed in therapeutic work that remains focused on sensate experience, holding a place for what cannot be put into words, must not be put into words, even while expanding the terrain of experience that can be symbolized.

References


5

The Coconstruction of "Psychoanalytical Choreography" and the Dancing Self

Working With an Anorectic Patient

Maria Paola Pacifici

I am persuaded that movement is by itself expressive beyond any intention.

I dance because I get from it a profound pleasure. ... I figure out dance as if it were a constant transformation of life itself.

Merce Cunningham

Dance and Creativity as an Expression of the Self

Picture a minimalist stage and a white sheet at the background, evoking images of purity and contrasts. The gracefulness of the choreography and the humanness of the dancers' presence on the stage completely capture the observer.